

tained effort either mental or physical. They are usually backward in school although they are intelligent, but seem unable to apply themselves sufficiently to keep up with the average. They are also physically unfit for the usual activities of childhood. They tire readily and prefer to be spectators rather than to participate actively in the games and amusements. They are not ill and usually it is impossible to show evidence of disease even under the most careful and rigid examination. One of the distinguishing characteristics is lack of nervous control. Therapeutically the results have been discouraging. They do fairly well in non-strenuous occupations. It is unusual to find children of this type the offspring of vigorous young persons. In a great majority of cases they are the offspring of a weakly mother with little resistance and of lessened endurance capacity. A strong vigorous mother will do much to offset the unfavorable influence on the progeny of a weakly male. The progeny of vigorous males is greatly handicapped by an inferior mother.

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**Bodily Mechanics.**—TALBOR and BROWN (*Am. Jour. Dis. Children*, September, 1920) report a number of cases of cyclic vomiting and other obscure intestinal conditions as the result of poor posture. They think that faulty bodily mechanics was responsible for a great loss of efficiency among adults during the war. Correcting it changed inefficient men into efficient soldiers. It is a condition common to all ages, and it is surprisingly prevalent. It is easily corrected and can be most economically done during childhood. It is responsible for most instances of diminished power of digesting fats in children. It is the cause for a certain amount of chronic constipation. It is the background and probably the cause of many, if not of most, of the cases of recurrent vomiting. In many instances the symptoms of acute abdominal pain in children, when associated with chronic constipation, is due to poor bodily mechanics. These symptoms are often so severe that they are confused with those of acute intestinal obstruction due to other causes. In the cases reported, in which the faulty postures have been corrected in conjunction with other treatment, the patients have shown a more speedy recovery than in cases without correction.

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**The Schick Test, Its Control, and Active Immunization Against Diphtheria**—BLAU (*New York Med. Jour.*, August 28, 1920) in his work used the capillary outfit as furnished by the New York Health Department. The technique is as follows: Break off one end of the capillary tube not having the black mark. Push the broken end through the neck of the rubber bulb until it punctures the diaphragm and enters the cavity of the bulb. Break off the other end of the tube. Expel the contents into one of the vials containing 10 e.c. of saline solution by placing the index finger over the opening in the larger end of the bulb. Rinse the capillary tube by drawing up saline solution several times. Cork the saline vial and shake the dilution. Inject 0.2 e.c. of the diluted toxin, representing one-fiftieth minimum lethal dose for the guinea-pig, intracutaneously on the flexor surface of the left forearm. The control test is proceeded with in the same manner using the capillary tube with the black mark, and making the injection into the flexor surface of the right forearm. The reactions should be observed at the

end of twenty-four and forty-eight hours, basing the final judgment upon the last reading. The positive reading becomes apparent at the end of from one to four days, averaging at the end of the second day, at a time when the pseudo-element of the reaction has disappeared. It consists of a definitely circumscribed area of redness, from 1 to  $2\frac{1}{2}$  em. in diameter, with a superficial scaling and a beginning brownish pigmentation. A strongly positive reaction will occasionally show vesiculation of the surface layers of the epithelium. The reaction gradually disappears in from one to four weeks going through various stages of scaling and pigmentation. After about two weeks a distinct brownish area is seen at the site of the injection. Occasionally a pseudo-reaction is manifested. This shows an indefinite area of redness of varying size, surrounded by a secondary areolar which shades into the surrounding skin. The pseudo-reaction appears earlier than the positive reaction in from six to eighteen hours, reaches its height in from twenty-four to thirty-six hours, and disappears by the end of from two to four days, at the time when the positive reaction becomes apparent, and may have a poorly defined area of pigmentation but no scaling. The combined reaction shows a positive and a pseudo-reaction in one. The positive element of the reaction becomes apparent at the end of from two to four days, at a time when the pseudo-reaction has disappeared. The appearance of the positive element is the same as the positive uncombined reaction. The appearance of the pseudo-reaction is the same as the uncombined pseudo-reaction, and resembles the reading at the site of the control test if there is a reaction at the control, with which it should be compared. The doubtful reaction is where the reaction is not typically positive negative, nor a pseudo-reaction. In these cases the reading should be made as positive. In the control reaction nothing is seen, but occasionally it shows a pseudo-reaction. The Schick test is positive between the ages of one and four years in about 32 per cent. of normal children. It is positive in a slightly larger proportion of measles cases, in twice as many scarlet fever cases, and in nearly three times as many cases of poliomyelitis. After the sixth year the proportion of positive reactions rapidly decreases, being positive in about 10 per cent. In adults 85 to 95 per cent. of the tests are negative. For active immunization a solution of undiluted toxin and antitoxin is used.

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**The Dietetic Treatment of Summer Diarrhea.**—GRIFFITH (*Arch. Ped.*, August, 1920) says that the correct management of the diet is the most important factor in treatment. The first and the most important step is the immediate and complete withdrawal of food at the beginning of the attack. It is advisable to instruct mothers that with any digestive disturbance whatever, food should be withdrawn without waiting to call the doctor. The second step is the removal of any food already in the intestines. Castor oil or magnesia are advised to accomplish this. If there is vomiting, it may be necessary to wait for its subsidence before giving the purgative. A large intestinal douche can, however, be given at once. The length of the period of starvation depends upon the case. A breast-fed baby may be kept from suckling for twenty-four hours. Bottle-fed babies usually require a longer time. Water should be given freely, and it is often a great relief to the mind of the mother, if she is allowed to use barley water. So long as the fever remains

showing that an infection is still present, resumption of the milk diet should be delayed. When it is started, it should be given in small quantities diluted and preferably skimmed, and the return to the original strength should be made gradually. An excess of fat or sugar may cause diarrhea. Broths thickened with starch substances or even thick porridges are of great value when the time for the return to food has come and the action of the milk is feared. In obstinate cases it is sometimes best to abandon the milk mixture and to use whey, casein milk, buttermilk, or the like. The thick gruels are very valuable as foods. On account of the starch, it is not advisable to continue their use over long periods. On account of the danger of relapse and recurrence restriction of the diet should be continued for the duration of hot weather. Gain of weight in these cases becomes of minor importance for the time. Acidosis is one of the great dangers during diarrhea.

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## OBSTETRICS

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UNDER THE CHARGE OF

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**The Prophylactic Forceps Operation.**—DELEE (*Am. Jour. Obst.*, October, 1920, No. 1) contributes a paper in which he urges that many patients be delivered by the use of forceps without waiting for spontaneous expulsion. His method is as follows: When the pains are well established and cervix partly dilated, morphin-scopolamin are given and  $\frac{1}{10}$  scopolamin given several times afterward. The patient's room is darkened and suggestion is employed. When the cervix does not dilate 15 grains of chloral and 40 grains sodium bromide are given by rectum, or gas and oxygen administered. It is important to obtain complete spontaneous dilatation of the cervix as slowly as possible; not only does the cervix dilate but the paracervical tissues retract which is most important and cannot be imitated by artificial means. When the head has left the cervix and rests between the levator and stretching the facia, ether is given to complete anesthesia and perineotomy is performed. The fetal heart sounds are carefully watched and forceps applied and patient delivered. Pituitrin is often injected as the placenta passes out through the vulva, aseptic ergot is also injected if there is any hemorrhage. The operator waits five to ten minutes before delivering the placenta. If necessary the operator disinfects his gloves carefully and if the placenta is not visible inserts the left hand into the vagina and lower segment, palm up, while the uterus is pushed down on the placenta and the placenta then slides along the hand. If there is bleeding more pituitrin is given and  $\frac{1}{4}$  grain of morphin and  $\frac{1}{10}$  scopolamin is then administered to reduce the quantity of ether required for repair work, prolonging narcosis for many hours postpartum and abolish the memory of the labor as much

as possible. The cervix is then repaired and also the perineum and pelvic floor. The writer illustrates his conception of the anatomy of the parts and when this paper was presented, employed models to illustrate his idea. For this method the writer claims that it saves the woman the debilitating effects of suffering in the first stage and the physical labor of the second stage; but little blood is lost by this procedure. This method preserves the integrity of the pelvic floor and other tissues and prevents the results which follow lacerations. The brain of the child is protected from injury and from the effects of prolonged compression. In the hands of those not expert, this method might produce bad results. In a mother infected before labor complications might arise. The writer has had no mortality; mothers and children have done well. It is interesting to note that the method of version at the end of the first stage of labor proposed by Potter of Buffalo is condemned by the writer. He states while in Potter's hands the operation of version is safe, in less skilful hands very bad results will follow. In his mind, however, the same argument applies with less force to his recommendation of the operation of prophylactic forceps. This paper was presented before the American Gynecological Society and the majority of opinion was strongly against the adoption of this method in all cases and by all those who practise obstetrics. It was recognized as a procedure appropriate for experienced operators only.

**Cranial and Intracranial Birth Injury.**—BAILY (*Am. Jour. Obst.*, October, 1920, No. 1) calls attention to the fact that a considerable proportion of stillbirths and early deaths are due to injury to the head of the child. In a few instances the prompt application of treatment might lower the mortality and morbidity. The mechanism of the injury has been described and illustrated. The veins of the cortex have little support as they enter the sinuses and hence pressure may readily rupture these vessels. In deformed pelvis the head will mold unnaturally and undue pressure is inevitable. The posterior parietal bone may often produce severe injury. When the skull is fractured there is usually rupture of the meningeal vessels, although this condition seems to be rare probably because the dura is loosely attached to the bone in the newborn. A bad application of the forceps or excessive force might produce such a result. Bleeding from surfaces of the cortex is often retained beneath the pia and if near the cortical centers may produce considerable damage. Hemorrhage into one of the ventricles may occur from rupture of the eoriplexus. The 40 cases proved by autopsy of cervical hemorrhage in infants, occurring at the Manhattan Maternity Hospital, are described in detail. Of these but 10 were not stillborn, 1 lived twenty minutes, another thirty, 1 three hours and others from fourteen hours to four days. But 2 of the children were delivered by forceps, 2 premature and 5 normal births. In the entire series 9 were forceps deliveries, 11 breech extraction, 5 preceded by version, 1 Cesarean case and 17 normal deliveries. The hemorrhage was diffuse in 18, especially marked under one bone in 11, diffuse, not in ventricle in 2, ventricle alone in 2, diffuse meningeal hemorrhage with thrombosis of the sinus in 1, 2 in the cerebellum, 2 in the pia mater, 2 in the dura mater. Five recent